EXHIBIT C

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NATIONWIDE LIFE INSURANCE COMPANY
Disclosure Statement

As an underwriting consideration for the acceptance of Stop Loss risk by Nationwide Life Insurance Company (the "Company"), the Policyholder is required to disclose the following pertinent information regarding all known eligible persons in the categories listed below as of the date that this Disclosure Statement is completed, but in no event more than 30 days before the proposed effective date. The Policyholder is further required to obtain all available information from a Utilization review firm, case management vendor and any other agent who may have knowledge of claims-related activity.

In the event that this Disclosure Statement is signed prior to the effective date of the stop loss policy, updated information must be provided through the day before the effective date if the information provided in this Disclosure Statement is no longer accurate or complete. Any updated information must be provided to the appropriate underwriting contact in a format similar to this Disclosure Statement.

Any individual previously disclosed who is not disclosed in this Disclosure Statement is assumed to be no longer covered under the Plan. Information provided in this Disclosure Statement, even though it may be for the same claimants disclosed earlier, may be cause for the rates, terms, or conditions of the proposal to be modified. It may even be cause for the proposal to be withdrawn. No information submitted with this Disclosure Statement as attachments will be accepted and included as a part of this Disclosure Statement unless 1) each attachment is clearly dated, numbered and marked as part of this Disclosure Statement and 2) all information listed below is provided for each covered individual. If a claim is made on any individual listed on an attachment not meeting the above criteria or listed below but without all required information as set forth below (information which, if included, would have affected the rates, factors, terms or conditions of coverage), the Company will have the right to deny the claim or revise the rates, factors, terms or conditions as of the effective date of coverage by providing written notice to the Policyholder.

1. Eligible persons provided with health care during the last 12 months where the expenses for health care exceeded or are expected to exceed 50% of the Specific Deductible;
2. Eligible persons with health conditions which have the potential to exceed 50% of the Specific Deductible in the next 12 months;
3. Eligible persons currently hospital or institution confined, or expected to be confined within 90 days of the effective date;
4. Employees absent from work due to disability as of the date of this disclosure;
5. Dependent children over the normal termination age who are being continued under a disabled or handicapped child provision;
6. Eligible persons who have had an organ or bone marrow transplant, or who have been evaluated for, or accepted into a transplant program.
7. Eligible persons who are currently on COBRA, Social Security disability continuance or any other leave of absence.

Rosecrance Health Network

See attached reports:

ELGCENS (eligibility census)
ISA (Individual Specific Analysis)
COBRA
SHL (suspended held claim)
SCL (suspended claims list)
Trigger
Pre Certification

Name_____ Date of Birth_____

Employee Number_____ Employee ☐ or Dependent ☐ Gender_____

Date illness or injury began_____

Date last worked_____

Date expected to return to work_____

Diagnosis or nature of disability_____

Current health status_____

Describe current and proposed treatment_____

Organ or bone marrow transplant candidate, yes/no_____

COBRA effective date/end date_____

Benefits paid in last 12 months_____

Claims currently pending_____

Claims denied in the last 12 months_____

Name_____ Date of Birth_____

Employee Number_____ Employee ☐ or Dependent ☐ Gender_____

Date illness or injury began_____

Date last worked_____

Date expected to return to work_____

Diagnosis or nature of disability_____

Current health status_____

Describe current and proposed treatment_____

Organ or bone marrow transplant candidate, yes/no_____

COBRA effective date/end date_____

Benefits paid in last 12 months_____

Claims currently pending_____

Claims denied in the last 12 months_____

Name_____ Date of Birth_____

Employee Number_____ Employee ☐ or Dependent ☐ Gender_____

Date illness or injury began_____

Date last worked_____

Date expected to return to work_____

Diagnosis or nature of disability_____

Current health status_____

Describe current and proposed treatment_____

Organ or bone marrow transplant candidate, yes/no_____

COBRA effective date/end date_____

Benefits paid in last 12 months_____

Claims currently pending_____

Claims denied in the last 12 months_____

Name_____ Date of Birth_____

Employee Number_____ Employee ☐ or Dependent ☐ Gender_____

Date illness or injury began_____

Date last worked_____

Date expected to return to work_____

Diagnosis or nature of disability_____

Current health status_____

Describe current and proposed treatment_____

Organ or bone marrow transplant candidate, yes/no_____

COBRA effective date/end date_____

Benefits paid in last 12 months_____

Claims currently pending _____

Claims denied in the last 12 months _____

The Policyholder, including it officers, employees and agents, through its authorized representative, hereby warrants and represents that the above list and any attachments meeting the requirements of an acceptable attachment to this Disclosure Statement as set forth above is complete and accurate and that nothing has been omitted. The Policyholder further acknowledges, understands and agrees that this information will be used by the Company to evaluate and determine if the Policyholder's risk is acceptable and if the rates, terms or conditions of the proposal should be modified.

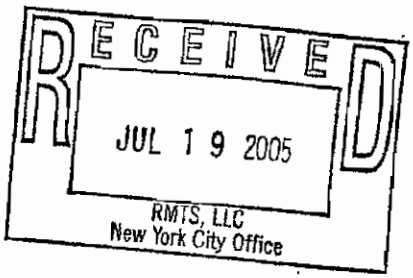
It is further understood that the Company shall rely on the information submitted in this disclosure in underwriting the Policyholder's application for Stop Loss Insurance. Should subsequent information become known which should have been disclosed in this Disclosure Statement or (if the Disclosure Statement is completed prior to the effective date of the policy) in updated disclosure as of the day before the effective date and would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the effective date of coverage, by providing written notice to the Policyholder. The Company will also have the right to deny a claim submitted for any covered individual for whom such information was not disclosed to the Company.

This information shall be treated as confidential.

Policyholder Rosecrance Health Network Third Party Administrator HCH Administration

Authorized Representative [signature] Authorized Representative_____

Date of Disclosure 6/7/05 Date of Disclosure_____



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                          Specific Analysis                    isa

        From rein code              To rein code

             From group RSHN        To group   RSHN

             From plan              To plan

   Report on:  paid, incurred, both or contract type? (p/i/pi or c) c

                  Print carryover amounts? (y/n) n

                  Include all claimants over 050%

                Print contracts in force as of 05/26/2005




           Do you want to process in background? (y/n): n

                  Is the above correct? (y/n/e): y
```

Rosecrance
Trigger 5-26-05

MEM-FIRST-NAMI	ENR-LAST-NAME	R-SOC-SEC-DA	CLH-INC-FROM-DAT	CLH-PAID-DAT	ILL-TOTAL-CHARG	TPAID	CLH-FREE-FORM-DIAG
[redacted]	[redacted]	319-64-0672	11/26/04	02/21/05	29.00	[redacted]	[redacted]
[redacted]	[redacted]	256-21-9327	03/04/05	03/28/05	190.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/18/05	87.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	59.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	32.00	[redacted]	[redacted]
WILLIAM	BOYKIN	575-84-1761	03/15/05	04/25/05	53.00	[redacted]	[redacted]
[redacted]	[redacted]	323-78-5976	07/09/04	08/09/04	188.00	[redacted]	[redacted]
[redacted]	[redacted]	323-78-5976	07/09/04	08/09/04	209.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	06/24/04	08/16/04	95.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	06/10/04	10/11/04	612.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	06/10/04	10/11/04	2,417.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	06/10/04	10/25/04	612.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	08/10/04	10/25/04	2,417.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	09/27/04	01/31/05	120.00	[redacted]	[redacted]
[redacted]	[redacted]	345-42-7762	02/07/05	03/07/05	120.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	99.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	64.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	191.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	213.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	223.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/05/04	08/09/04	253.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/02/04	08/09/04	53.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/08/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	640.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/04/04	08/09/04	691.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/04/04	08/09/04	93.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/02/04	08/16/04	221.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/16/04	53.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/01/04	08/16/04	250.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/02/04	08/30/04	853.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	07/08/04	09/13/04	161.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	08/25/04	09/27/04	132.00	[redacted]	[redacted]
[redacted]	[redacted]	326-66-9130	08/25/04	09/27/04	127.00	[redacted]	[redacted]

UR Notes 5-03-05

Update:
Mr. Boykin is waiting, he's finished his work up and as below is medically approved. So now the hard part, the wait.. that is it for him...lw
Linda J. Walker RN BSN
Director Medical Affairs
050305

Mr. Boykin is ready and approved for his liver transplant. An approval letter was sent to Univ of Wisc 032205. An agreement with Interlink is in place. So now we wait...that wait could be up to 3 years.... so nothing too new.... this is the hard part for the patient...lw

021105:
I ran a report from 100104 to current and the total paid are $3232.43. Billed was $4290.45.. I will need to call Mr. Nicholas again as he appears to be at a stand still. Last bill was 011405....not much change lw

An update on William Boykin: there is nothing new on this member...he is still in the work up stage as he has been since last August. When the medical work up is done, and then I'll get medical approval. Then he will continue waiting for an organ. If he were to have a living donor for the liver, he could be transplanted sooner. But if he is to receive a cadaver liver, then the wait is still 2-3 yr + ... the Interlink agreement with U of WI @ Madison is in place for the TPL...
Linda J. Walker RN BSN
Director
120604

Andrea Garrison #1 323586574, DOB 010388: this young lady has a psychiatric diagnosis that precipitated an admission on 020305 to 020705. The benefit is 30 days inpt & 20 visits outpt per yr with coordination thro the EAP.. I was not provided a RIP due to method of contact, but

Wm Boykin ee 575841761, DOB 122556: question this time is in reference to the agreement and the revised rates which Interlink did with the Univ of Wisc Madison. MELD score of 12; the TPL agreement is with the Univ of Wisc in Madison;
The agreement is as follows:
Case rate of $77,250.00 (living donor) for hospital & $68,577.00 professional fees
Case rate $72,950 (cadaver) for hospital & $48,625.00 for professional from day one thro day 27.
The outlier per diem for hospital if neeessary, is $4,711.00 til discharge & $500.00/day...Interlink reprices all claims for us..
All pre & post discharges charges are payable at 85% billed charges. I willl have the agreement faxed to Michelle M. faxed @ 1405.

Also the question of why was the agreement revised? The University of Wisc revises the TPL agreement annually with Interlink so that revision of rates needed to be so reflected. Not all Universities adjust annually but they certainly can.. lw

Linda J. Walker RN BSN
Director Medical Affairs
051105

Confidential Information

Memorandum of Understanding

Date: September 13, 2004

Revised 3/2/05

To: Lori Madden
University Health Care, Inc.

From: John Van Dyke
INTERLINK Health Services, Inc.

Re: Mr. William Boykin
A Potential Living Donor or Cadaveric Donor Liver Transplant Candidate
D.O.B.: 12/25/1956
ID Number: 575-84-1761

This Memorandum of Understanding has been prepared to formalize the agreement between the health benefit plan of Rosecrance Health Network and University Health Care, Inc., on behalf of University of Wisconsin Hospital & Clinics (UWHC) and University of Wisconsin Medical Foundation (UWMF), for the above named patient's potential (living donor or cadaveric donor) liver transplant. Once executed, this agreement shall remain valid as long as there are no changes in the patient's medical status, insurance benefit program, or program eligibility before the transplant occurs.

Case Rate Inclusions & Outlier Provisions

Hospital - UWHC

The health benefit plan of Rosecrance Health Network agrees to reimburse the University of Wisconsin Hospital & Clinics the lesser of 90% of billed charges or a hospital case rate of $77,250 (living donor) or $72,950 (cadaveric donor) for the first 27 days of care, beginning the date of admission for the transplant. If the patient's stay exceeds 27 days, then an outlier per diem rate of $4,711 will apply until discharge. Organ acquisition charges are included in the case rate. In no event shall UWHC receive less than fifty percent (50%) of billed charges.

NOTE FROM INTERLINK: Rates and provisions as presented within this document are not valid unless this document is executed and returned to INTERLINK either before admission, or within 30 days, which ever comes first. If the patient is not admitted and this document is not returned within 30 days from 3/2/2005, which is this document's creation date, a new document with new rates may be necessary.

Confidential Information

Professional - UWMF

The health benefit plan of Rosecrance Health Network agrees to reimburse the University of Wisconsin Medical Foundation the lesser of 90% of billed charges or a case rate of $68,577 (living donor) or $48,625 (cadaveric donor) for the first 27 days of care beginning on the date of admission for the transplant stay. If the stay exceeds 27 days, then a per diem of $500 for each additional day until discharge will apply. In no event shall UWMF receive less than fifty percent (50%) of billed charges.

The hospital and professional rates in effect at the time the patient begins the transplant stay shall supercede the rates listed in this MOU should they be different.

Discharge Medications shall be reimbursed at 100% of billed charges.

Pre-Transplant & Post-Transplant Care Provisions

Outpatient hospital and professional services, delivered from evaluation to date of admission for the transplant stay and post-transplant services beginning on date of discharge and ending one year post-transplant will be paid at 85% of billed charges.

Inpatient hospital and professional services, delivered from evaluation and ending on the date of admission for the transplant stay and post-transplant beginning on date of discharge and ending one-year post-transplant will be paid at 85% of billed charges.

Retransplantation Provisions

Retransplant services during the initial transplant admission will be payable at the lesser of 90% of billed charges or a case rate of $95,976 ($46,976 hospital and $49,000 professional, for living donor) or $75,133 ($40,833 hospital and $34,300 professional, for cadaveric donor). Retransplantation provided after the initial transplant discharge will be treated as if it were the first transplant.

Death During Transplant Admission Provisions

If the patient expires during the transplant admission, the lesser of 90% of billed charges or the case rate and any applicable outlier per diems would be paid.

Claims Forwarding & Payment Provisions

All hospital bills, physician bills, and any other bills related to this transplant are to be sent to INTERLINK for repricing and review. INTERLINK will review and adjust all bills to contracted terms consistent with this MOU and promptly forward them to HCH Administration for payment. University of Wisconsin Hospital & Clinics and University of Wisconsin Medical Foundation shall send all bills related to this transplant to:

NOTE FROM INTERLINK: Rates and provisions as presented within this document are not valid unless this document is executed and returned to INTERLINK either before admission, or within 30 days, which ever comes first. If the patient is not admitted and this document is not returned within 30 days from 3/2/2005, which is this document's creation date, a new document with new rates may be necessary.

Confidential Information

INTERLINK Health Services
Attn: Transplant Claims
4950 NE Belknap Court, Suite 205
Hillsboro, OR 97124

Payment of the adjusted bills are to be made to University of Wisconsin Hospital & Clinics and University of Wisconsin Medical Foundation, respectively, within 30 days of filing to INTERLINK.

INTERLINK Health Services is not responsible for payment of these claims.

Linda Parker RN BSN Date: 3-14-05
The health benefit plan of Rosecrance Health Network,
or other authorized representative
Director Medical Affairs

IMPORTANT: Payment of benefits or the amount of benefits is not guaranteed. Payment is subject to all terms, provisions, conditions, limitations and exclusions (including those regarding pre-existing conditions) of the patient's benefit plan. The patient must be eligible for plan benefits at the time services are rendered.

NOTE FROM INTERLINK: Rates and provisions as presented within this document are not valid unless this document is executed and returned to INTERLINK either before admission, or within 30 days, which ever comes first. If the patient is not admitted and this document is not returned within 30 days from 3/2/2005, which is this document's creation date, a new document with new rates may be necessary.

FAXED